Authorization for Use or Disclosure of Medical Record Information
Auburn University Medical Clinic

AUBURN UNIVERSITY

Patient Information

Patient Full Name: _____ Date of Birth: _____/_____/_____

Social Security #: _____

Patient Address: _____ Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Email: _____

Release Information To

I hereby authorize Auburn University Medical Clinic (AUMC) to release my medical record information to:

☐ Mail Copies To ☐ Hold for Patient Pick-up ☐ Discuss Medical Information With

Name/Facility: _____ Attention: _____

Address: _____ Phone: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Fax: (_____) _____ - _____

Purpose of Request: ☐ Personal ☐ Continuing Care (second opinion or refer to specialist) ☐ Insurance ☐ Work Related
☐ Legal ☐ Transfer out/Reason? _____
☐ Other _____

Information to be Released

☐ Please provide a 2 year abstract (includes 5 years of diagnostics)
Copy fee capped at $25.00 for a 2 year abstract. Notarized additional $25

☐ Other – Please be specific, include dates and clinicians under comments.
Note: You will be invoiced at the allowable AL Statute rate.
Copy Fee: $1.00 per page for first 25 pages; $0.50 per page
for over 25 pages, plus postage ($3), search fee ($5), Notarized ($25)

Comments

AUMC does not provide copies of records received for another physician or institution.
Please request these records directly from the original healthcare provider.

Authorization to Release Protected Information

Required Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check One. Initials

I ☐ **DO** ☐ **DO NOT** want **Psychiatric Treatment Notes** released. _____
I ☐ **DO** ☐ **DO NOT** want information about **Mental Health** released. _____
I ☐ **DO** ☐ **DO NOT** want information about **HIV Tests & Related Information** released. _____
I ☐ **DO** ☐ **DO NOT** want information about **Alcohol and/or Substance Abuse** released. _____
I ☐ **DO** ☐ **DO NOT** want information about _____ released. _____
Other sensitive information?

STOP Please confirm that you have put a checkmark and initialed ALL the protected information categories above, regardless if they are applicable or not. If form is incomplete or if protected information is **not** released we may be unable to fill this request.

_____ _____
Patients Signature **Date***

_____ _____
Parent/Legally Recognized Representative Signature **Date**

_____ _____
Witness **Date**

Know Your Privacy Rights
Refer to the HIPAA
PRIVACY NOTICE

FAX NUMBER
(334) 528-6780
E-Mail:aumcmedrecords@eamc.org

***This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Medical Records Department except to the extent that AUMC has already completed action on.**

FOR MEDICAL STAFF TO COMPLETE

☐ *FAXED* ☐ *MAILED* ☐ *HAND DELIVERED* *COMPLETED BY:* _____ *DATE:*_____ *Revised 11/2011*